EDITORIALS

Of Minorities, Majorities, Medicine and Health

WHAT HAS HAPPENED to majority rule? It is still an article of faith that our government expresses the will of the majority and that indeed decisions are made by a vote of the majority wherever the democratic process is operative. But in practice is it a real majority that always makes the decisions? Often it seems that what is decided is actually the product of interaction and negotiation among the parties with most at stake which are nearly always numerical minorities with one or another kind of special interest. It is relatively seldom that one senses that the real majority has spoken and been heard. The passage of Proposition 13 in California (which has had national repercussions) might be cited as one of the rare examples in recent years where the majority spoke as the majority on an issue, and was heard. More often the will of the real majority is unfocused and the democratic process in government rather seems to reflect the will of well-organized (and often well-funded) special interest groups rather than the views of an ordinarily less aggressive and less focused majority.

Perhaps it was ever thus, and perhaps it can never be otherwise. In any case our social, economic and political system is becoming more complex and interdependent and also is comprised of an increasing number of more or less autonomous and independent groups and entities. It is only natural that these should band together in various combinations to promote their own common interests within the interdependent whole. And it is only natural that they marshal the resources and develop the skills to advocate their causes and interests as effectively as possible within this whole. And every year this process becomes more refined and special interest advocates are becoming more powerful and indeed more successful.

The medical profession finds itself in the thick of these developments, and as a social, economic and political minority has performed with commendable skill and effectiveness in this very real world. But unlike most of the other minority special interest groups, the medical profession—because of its professional expertise—plays a larger role as advocate for the health and health care of all the individual persons who are or may become patients (actually the social, economic and political majority). In yet another dimension it acts as the advocate for the health and well-being of the environment in which everyone, both the numerical majority and all the numerical minorities, must live. In these dimensions the special interest of the medical profession as a social, economic and political minority is much larger than just the protection and advancement of its self-interests as a profession. The medical profession can and should be the advocate and spokesman for the undifferentiated majority in virtually anything pertaining to health and health care.

During the past few decades the medical profession in America has become much more active and aggressive in matters social, economic and political. Its advocacy may be expected to become even more effective if it can become identified as the recognized authoritative advocate of the interests not only of minorities, but also of the majority

in matters of health and health care. And one may safely predict that as the anticipated glut of physicians becomes a reality, many more physicians will have time and energy to give to the social, economic and political advocacy of the profession in these wider dimensions of professional responsibility. If and as this occurs, and if and as the profession itself develops the necessary leadership, public support will develop to a much greater extent than has been the case so far. And if and when this happens, the social, economic and political majority will come to have a voice and an advocate in the medical profession to express the real majority's real interests in health and health care.

—MSMW

Management of Bleeding Esophageal Varices

THE HOPE THAT randomized trials would make the treatment of variceal bleeding rational has not been realized, nor is it likely to be. In both cooperative trials and single-hospital studies there seems no escape from problems of (1) preselection of patients by patterns of referral, (2) diminishing populations being treated in specialized centers because of skilled surgery practiced in community hospitals, (3) inevitable violations of experimental protocol due to exigencies of care and (4) inability to control for behavior of patients after they leave the hospital.[1,2] Moreover, bias and error affect factors by which the success of treatment should be judged, such as survival rates, assessments of encephalopathy and hepatic function, and the role of the magnitude and direction of portal venous flow in determining outcome.[1,3,4]

No factor dominates results more than the state of the liver. With any reasonable therapeutic program, survival rates in patients with excellent hepatic function will be nearly 100 percent, with mediocre function 50 percent to 60 percent, and with poor function 10 percent to 30 percent.[5,6] The objective is to avoid errors in judgment and technique that worsen these odds.

Rikkers' comprehensive Medical Progress article "Operations for Management of Esophagogastric Variceal Hemorrhage" in this issue provides a discriminating guide to both the facts and equivocations that support these views and the arguments that oppose them. A program useful for managing treatment of bleeding esophageal varices follows.

In a patient with presumed bleeding of varices that does not stop spontaneously, an intravenous drip of vasopressin is prepared to run at 0.3 to 0.4 U vasopressin per minute (4 to 6 μU per kg of body weight per minute, 10 ampules of 200 U vasopressin per 500 ml of 5 percent dextrose solution). Although formerly advised, a discrete intravenous injection of 10 U vasopressin has no proved value and may depress cardiac output without controlling bleeding. Somatostatin and propranolol hydrochloride may be superior to vasopressin, but there is not enough evidence to define their roles in controlling variceal hemorrhage.

If bleeding is refractory to vasopressin, the Minnesota (four-lumen) modification of the Sengstaken-Blakemore tube is introduced, with the gastric balloon inflated with 400 ml of air and the esophageal balloon to 30 to 40 mm of mercury; both the esophageal and gastric ports should be connected to suction after the tube is correctly situated.[7] Traction on the tube is usually neither required nor desirable. Only if bleeding persists is 1-kg traction used to help tamponade a bleeding varix in the upper stomach. Traction must be discontinued within 24 hours to prevent necrosis of the esophagogastric junction.

After stability is achieved, fiberoptic esophagogastroscopy is done to establish the source of bleeding. Gastritis rather than varices will be the culprit a third of the time.[8]

Emergency angiography is not required if the diagnosis is secure and if bleeding is controlled. If bleeding persists, angiography is carried out to investigate the possibilities of hemorrhagic gastritis (which may sometimes be controlled by intraarterial infusion of vasopressin) and of bleeding peptic ulcer (which may be amenable to arterial embolization with polyvinyl alcohol or Gianturco-Wallace coils).[9]

Angiography also delineates portal venous anatomy in preparation for an emergency portacaval shunt when other means fail to control bleeding varices or the portal hypertension-gastritis syndrome. Even though the best-risk patients regularly survive an emergency portacaval shunt, emergency shunts are avoided because they double the overall postoperative mortality of